

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-019159**

Registration District No. **042** Primary Registration District No. **1000** Registrar's No. **615**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

1 **5117**

2 **5117**

3

4 **1**

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**9260X**

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11

12 **2-0**

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

**M.E. Grimes, M.D.**

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>                 |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN <b>St. Joseph,</b>   |                                  | c. CITY OR TOWN <b>St. Joseph,</b>  |   |
| Length of stay in lb <b>28 years</b>  |                                  | Inside Limits <b>Yes</b> <input checked="" type="checkbox"/> No <input type="checkbox"/>  |   |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION <b>Meth. Hosp. &amp; Med. Center</b>   |                                  | d. STREET ADDRESS (If outside, give location)<br><b>3410 Jackson Street</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>JANET MC CLARD JONES</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>May 21, 1963</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 8, 1933</b> |
| 9. AGE (last birthday)<br><b>29</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Teacher</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Mark Twain School</b>   |   |
| 11. BIRTHPLACE (City and state or country)<br><b>Macon, Missouri</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>  |   |
| 13a. FATHER'S NAME<br><b>Alfred I. McClard</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Nellie Mae Morrison</b>   |   |
| 14. NAME OF HUSBAND OR WIFE<br><b>John K. Jones</b>   |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                    |   |
| 16. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT<br><b>Mr. John K. Jones-St. Joseph, Missouri</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremia</b><br>DUE TO (b) <b>Hypertension</b><br>DUE TO (c) <b>Nephrotic M. Uncontrolled</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)<br><b>total Blindness</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>2 yrs</b><br><b>20 yrs</b>  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>   |   |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)  |                                  | 20c. TIME OF INJURY<br>Hour a.m. p.m. Month, Day, Year  |   |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |                                  | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |
| 20f. CITY, TOWN, OR LOCATION  |                                  | COUNTY STATE  |   |
| 21. I attended the deceased from <b>5/17/63</b> to <b>5-21-63</b> and last saw her alive on <b>5/20/63</b><br>Death occurred at <b>6:40 AM</b> on the date stated above, and to the best of my knowledge, from the causes stated.   |                                  | 22a. SIGNATURE (Degree or title)<br><b>M.E. Grimes, M.D.</b>  |   |
| 22b. ADDRESS<br><b>St. Joseph, Mo</b>   |                                  | 22c. DATE SIGNED<br><b>5/21/63</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE<br><b>May 23, 1963</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park Cemetery</b>   |                                  | 23d. LOCATION (City, town, or county)<br><b>St. Joseph, Missouri</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Meierhoffer-Fleeman Inc., St. Joseph, Mo.</b>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>May 23, 1963</b>   |   |
| 26. REGISTRAR'S SIGNATURE<br><b>Mrs. Clark Goodell</b>  |                                  |   |   |

USE BLACK INK  
OR  
TYPEWRITER RIBBON

JUN 4 1963

Permit issued 5-23-63

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# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_ Signed \_\_\_\_\_  
Signature of Student Embalmer

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.